LEAVE OF ABSENCE
FELLOWS & SUB-SPECIALTY RESIDENT

✓ Office Managers are responsible for making Fellows/Sub-Specialty Residents aware of their rights concerning Medical Leave and Family Medical Leave. If Fellows/Sub-Specialty Residents have questions, please refer them to either Karen Brooks.
✓ Office Managers are responsible for notifying HR when the employee begins medical leave and returns.
✓ Fellows/Sub-Specialty Residents *can not return to work without* a doctor’s note authorizing their return.
✓ Office Managers are responsible for collecting the documentation and forwarding the information to Karen Brooks.
✓ **IF THE FELLOW/SUB-SPECIALTY RESIDENT EXCEEDS THE ALLOWED AMOUNT OF VACATION/SICK TIME, THE TIME MUST BE MADE UP. AS A RESULT, THEIR END DATE WILL BE EXTENDED.**

**DOCUMENTATION NEEDED**

**UAB**

Medical Leave

✓ Family Medical Leave of Absence Request Form
✓ Doctor’s Note
✓ Accrual Form

Family Medical Leave

✓ Same as Medical Leave
✓ Certification from health care provider if employee is caring for child, spouse, or parent having a serious health condition.

**HSF**

Medical Leave

✓ Physician must complete Family Medical Leave of Absence Request Form
✓ Accrual form

Family Medical Leave

✓ Same as Medical Leave
FAMILY AND MEDICAL LEAVE OF ABSENCE REQUEST FORM
January 31, 2003 Revision

I request to be placed on UAB's family and medical leave of absence based on the attached certification from a health-care provider or the attached documentation related to adoption or foster care placement.

Full Name (Please print/type): ____________________________
Social Security Number: ____________________________
Department: ____________________________
Phone Number: ____________________________
Request Leave Start Date: _____/____/_____
Requested Leave End Date: _____/____/_____

REASON FOR LEAVE OF ABSENCE:

FAMILY-RELATED REASONS: (Maximum time allowed is 12 work weeks)

☐ Birth of child or to care for the baby. (Attach copy of the birth certificate or certification from a health-care provider. Employee's entitlement to leave of absence expires twelve months from the child's date of birth.)

☐ Adoption of a child by the employee. (Attach a copy of the adoption papers. Employee's entitlement to leave of absence expires twelve months from the date of adoption.)

☐ Placement of a child with the employee for foster care. (Attach a copy of the foster care placement papers. Employee's entitlement to leave of absence expires twelve months from the date of foster care placement.)

☐ Care of a child, spouse, or parent (but not in-laws) having a serious health condition. (Attach a copy of certification from a health-care provider. Children 19 years or older are not included unless they are incapable of self care due to mental or physical disabilities.)

EMPLOYEE HEALTH CONDITION: (Maximum time allowed is 16 work weeks)

☐ Medical leave of absence for a serious health condition that makes me unable to work. (Attach a copy of certification from a health-care provider. See additional provisions in the You & UAB Handbook for Administrative, Professional, and Support Personnel.) Intermittent medical leave for the employee's own health condition is limited to a maximum of 12 work weeks.

I REQUEST TO TAKE MY FAMILY AND MEDICAL LEAVE OF ABSENCE INTERMITTENTLY DUE TO:

☐ Serious health condition of myself, child, spouse, or parent because of medical necessity.

☐ Birth, adoption, or foster care placement -- Requires written approval of one's supervisor and/or department head.

I understand that I must first use all of my accrued personal holiday and vacation time (and accrued sick leave in the case of employee health condition or a health condition of child, spouse, or parent if they are living in the same household as the employee) at the beginning of my family and medical leave of absence as a part of my leave of absence and before the unpaid portion begins. I understand that if I do not return to work after the leave, UAB may recover payments for health insurance made by UAB during my leave of absence. I understand that failure to return to work on the date stated above as the leave end date or that misrepresentation of facts on this form will jeopardize my reinstatement at UAB.

Employee Signature: ____________________________ Date: ____________________________

☐ I have been advised of this employee's intent to take the indicated family and medical leave of absence, and, where appropriate such as for leave taken intermittently, I approve the request.

☐ The employee indicated above has not specifically requested a family and medical leave of absence, but I am designating the employee's leave as a leave which qualifies under the Family and Medical Leave Act. I am notifying the employee of my intent by providing him/her a copy of this completed form.

Supervisor (if applicable): ____________________________ Date: ____________________________
and/or
Department Head: ____________________________ Date: ____________________________

Department: Attach to the personnel action form related to the family and medical leave of absence a copy of this completed form and a copy of relevant sick leave, personal holiday, and vacation time accrual records for monthly paid employees.
YOUR RIGHTS

under the

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

FMLA requires covered employers to provide up to 12 work weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

REASONS FOR TAKING LEAVE: Unpaid leave must be granted for any of the following reasons:

☑ To care for the employee’s child after birth, or placement for adoption or foster care;
☑ To care for the employee’s spouse, child, or parent, who has a serious health condition; or
☑ For a serious health condition that makes the employee unable to perform the employee’s job.

At the employee’s or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

☑ The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable.”
☑ An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION:

☑ For the duration of FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan.”
☑ Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
☑ The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

UNLAWFUL ACTS BY EMPLOYERS. FMLA makes it unlawful for any employer to:

☑ Interferes with, restrain, or deny the exercise of any right provided under FMLA;
☑ Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

ENFORCEMENT:

☑ The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
☑ An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State Law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

US Department of Labor,
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

Any inquiries or complaints concerning the application of the Family and Medical Leave Act of 1993 and its implementing regulations as they relate to The University of Alabama at Birmingham should be directed to any one of the following persons, as appropriate:

Human Resource Management Relations Office
(205) 934-4458

Human Resource Management Benefits Office
(205) 802-3458

The University of Alabama at Birmingham encourages individuals who have complaints to utilize UAB’s internal grievance procedure prior to contacting an outside agency. If you desire to utilize UAB’s internal grievance procedure contact: the Office of Human Resource Management Relations.

Approved July 1993
Revised January 31, 2003
FAMILY MEDICAL LEAVE OF ABSENCE REQUEST FORM

I request to be placed on UAHSF's family/medical leave of absence based on the attached certification from health care provider or the attached documentation related to adoption or foster care placement.

FULL NAME: ___________________________ S.S.# ______________

Department: ___________________________ Phone #: __________________

Requested Leave Start Date: _____ / _____ / _____
Requested Leave End Date: _____ / _____ / _____

REASON FOR LEAVE OF ABSENCE: (Maximum time allowed is twelve (12) weeks)

Family-Related Reasons:

____ Birth of child or to care for the baby. (Attach copy of the birth certificate or certification from a health care provider. Employee's entitlement to leave of absence expires twelve months from the child's date of birth.)

____ Adoption of a child by the employee. (Attach a copy of the adoption papers. Employee's entitlement to leave of absence expires twelve months from the date of adoption.)

____ Placement of a child with the employee for foster care. (Attach a copy of the foster care placement papers. Employee's entitlement to leave expires twelve months from the date of foster care placement.)

____ Care of a son, daughter, spouse or parent (but not in-laws) having a serious health condition. (Attach a copy of certification from a health care provider. Children 18 years or older are not included unless they are incapable of self-care due to mental or physical disabilities.)

Employee Medical Condition:

____ Medical leave of absence for a serious health condition that makes me unable to work. (Attach a copy of certification from a health care provider. See additional provisions in the UAHSF Employee Handbook.)

I request to take my Family and Medical Leave of Absence intermittently due to:

____ Serious health condition of myself, son, daughter, spouse or parent.

____ Birth, adoption, or foster care placement -- requires written approval of supervisor and/or department head.

I understand that I must first use all of my accrued sick leave, personal holiday and vacation time at the beginning of my family/medical leave of absence as a part of my leave of absence. I understand that if I do not return to work after the leave, UAHSF may recover payments for health insurance made by the UAHSF during my leave of absence. I understand that failure to return to work on the date stated above as the leave end date or that misrepresentation of facts on this form will jeopardize my reinstatement at the UAHSF.

Employee Signature: ___________________________ Date: _____ / _____ / _____

Department Supervisor: ___________________________ Date: _____ / _____ / _____

Send original to UAHSF Human Resources Department. Attach a copy of this completed form to a Personnel Action Form (PAF) for the family/medical leave of absence and a copy of accrual records for monthly-paid employees and send to UAHSF Benefits Office, JNBW Suite 114. Submit PAF with physician's release attached upon the employee's return from leave. A PAF does not have to be submitted for intermittent leave.

Revised 12/04
1. Employee's Name

2. Patient's Name (If different from employee)

3. Page 4 describes what is meant by a “serious health condition” under the Family and Medical Leave Act. Does the patient’s condition qualify under any of the categories described? If so, please check the applicable category:

(1) (2) (3) (4) (5) (6) , or None of the above

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient’s present incapacity if different):

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

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1 Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

2 “Incapacity,” for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.
6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?
8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date
A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity² of more than three consecutive calendar days (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

      (1) Treatment³ two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

      (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

   A chronic condition which:

      (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;

      (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

      (3) May cause episodic rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

   A period of Incapacity² which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of Incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.